



Realizing good care within a context of cross-cultural diversity: An ethical guideline for healthcare organizations in Flanders, Belgium

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ABSTRACT

In our globalizing world, health care professionals and organizations increasingly experience cross-cultural challenges in care relationships, which give rise to ethical questions regarding “the right thing to do” in such situations. For the time being, the international literature lacks examples of elaborated ethical guidelines for cross-cultural healthcare on the organizational level. As such, the ethical responsibility of healthcare organizations in realizing cross-cultural care remains underexposed. This paper aims to fill this gap by offering a case-study that illustrates the bioethical practice on a large-scale organizational level by presenting the ethical guideline developed in the period 2007–2011 by the Ethics Committee of *Zorgnet Vlaanderen*, a Christian-inspired umbrella organization for over 500 social profit healthcare organizations in Flanders, Belgium. The guideline offers an ethical framework within which fundamental ethical values are being analyzed within the context of cross-cultural care. The case study concludes with implications for healthcare practice on four different levels: (1) the level of the healthcare organization, (2) staff, (3) care receivers, and (4) the level of care supply. The study combines content-based ethics with process-based benchmarks.

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Introduction

Healthcare organizations around the world provide healthcare for migrant patients every day, bringing with it many challenges on various domains. Most of the international academic literature on healthcare for migrant and minority patients comes from Western countries with a significant amount of non-Western migrant and minority population, such as Canada (Asanin & Wilson, 2008; Gushulak, Pottie, Roberts, Torres, & DesMeules, 2011; Kirmayer et al., 2011), the US (Cristancho, Garces, Peters, & Mueller, 2008; Ivanov & Buck, 2002), the UK (Hargreaves et al., 2006; Kai et al., 2007), Spain (Carrasco-Garrido, Jiménez-García, Hernández Barrera, López de Andrés, & Gil de Miguel, 2009; Hernández-Quevedo & Jiménez-Rubio, 2009), and the Scandinavian countries (Hultsjö & Hjelm, 2005; Norredam, Mygind, Nielsen, Bagger, & Krasnik, 2007). Comparative European data are also extensively available (Carta, Bernal, Hardoy, & Haro-Abad, 2005; Lindert, Schouler-Ocak, Heinz, & Priebe, 2008; Mladovsky, 2007; Norredam, Nielsen, & Krasnik, 2010; Priebe et al., 2011). Predominant focus in

these studies is on evidence of disparities in health and healthcare between the various ethnic groups (migrants, minorities, majority groups) within the same country. Inequalities in access and use of healthcare services by migrants and minorities (Bollini & Siem, 1995; Gushulak et al., 2011; Kai et al., 2007; Mladovsky, 2007), lower quality of care received and lower health outcomes are increasingly exposed (Fiscella, Franks, Gold, & Clancy, 2000; Trevino, 1999). Primary causes are language and communication problems between practitioners and patients (Asanin & Wilson, 2008; Gushulak et al., 2011; Kirmayer et al., 2011; Priebe et al., 2011), lower health literacy in migrant patients (Gushulak et al., 2011; Kirmayer et al., 2011), cultural differences and professional uncertainty (Asanin & Wilson, 2008; Gushulak et al., 2011; Kai et al., 2007; Priebe et al., 2011), negative attitudes and distrust among professionals and patients (Priebe et al., 2011), higher socioeconomic stressors in minority groups (Asanin & Wilson, 2008; Dunlop, Coyte, & McIsaac, 2000; Kirmayer et al., 2011), difficulties in arranging care for undocumented patients (Priebe et al., 2011), and issues during the hospital stay (WHO Europe MFH Project Group, 2004).

Existing studies on standards, guidelines and good practices (Bischoff, 2003; Henley & Schott, 1999; Owen & Khalil, 2007; Priebe et al., 2011; Schulze, Trummer, Krajic, & Pelikan, 2003; Tugwell et al., 2011; WHO Europe MFH Project Group, 2004) focus on

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needs assessments, recommendations for improving the responsiveness of healthcare services to the needs of migrant and minority patients, effective interventions in clinical practice, organizational support for cultural competence, and on monitoring demographic and epidemiological data about minority and migrant patients. The general thread in these guidelines is the aim of realizing good quality care for all, regardless of the patients' ethnic and cultural background. All the studies stress the importance of the organizational structure in this regard. Realizing cross-cultural care encompasses more than just the clinical practice and the patient–doctor relationship. It is a broad process, realized by migrant-friendly organizations with many stakeholders (WHO Europe MFH Project Group, 2004).

Ethical issues of cross-cultural care turn up in three ways. (1) First, we see that all of the above mentioned studies touch on fundamental ethical problems, such as actual inequalities in access and use of healthcare services by migrants and minorities, lower quality of care received and lower health outcomes. These are pressing issues of justice and equity in healthcare (Denier, 2007) that are constantly present in the literature but never elaborated. (2) Secondly, a significant strand of literature is devoted to philosophical, social or anthropological analysis of the relationship between values, beliefs and practices and the question whether or not ethical values can be considered as being universal in nature. In what way is the bioethical discipline a sole product of Western thought (Ten Have & Gordijn, 2011)? To what extent does respect for cultural diversity mandate tolerance of the beliefs and practices of other people? (Árnason, 2001; Brannigan, 2000; Macklin, 1998)? Do we possess common models of moral reasoning or is there a limit to the capacity of bioethics to resolve complex cases and disputes in cross-cultural care (Baker, 1998; Durante, 2009; Jecker, 2010; Turner, 2003, 2004)? The essential question of these theoretical studies on cross-cultural bioethics is: How can we avoid moral imperialism without ending up in ethical relativism? (3) The third strand of ethical literature is devoted to cross-cultural analysis in various, well-delineated domains of clinical ethics in multicultural settings (Coward & Ranatakul, 1999), such as end-of-life decision-making (Kagawa-Singer & Blackhall, 2001; Koch, Braun, & Pietsch, 2000; Turner, 2002), family and informed consent (Ho, 2006), cross-cultural geriatric ethics (Moody, 1998), access and utilization of critical care (Hawryluck, Bouali, & Danjoux Meth, 2011), paediatrics (Westra, Willems, & Smit, 2009), and the clinical encounter as such (Betancourt, Green, & Carillo, 2000; Donnelly, 2000).

For the time being, the international literature lacks examples of elaborated *ethical guidelines* for cross-cultural healthcare on the *organizational* level. Although in the past few years, the idea of culturally competent care gained the attention of healthcare organizations as an important *organizational* strategy to improve quality and eliminate ethnic disparities in healthcare (Betancourt, Green, Carillo, & Park, 2005; Chun, 2009; Dotson & Nuru-Jeter, 2012), examples of organizational *ethical* guidelines on cross-cultural care remain, as yet, non-existent in the international literature. This means that the *ethical* responsibility of healthcare *organizations* in realizing cross-cultural care remains underexposed.

With this case study, we aim to fill this gap by focusing on the following question: What is the ethical responsibility of healthcare organizations in realizing cross-cultural healthcare? Which ethical views of patient and care will guide the cross-cultural process? This paper illustrates the ethical practice in cross-cultural care on a large-scale organizational level by presenting the ethical guideline for cross-cultural care, developed in 2007–2011 by the Ethics Committee of *Zorgnet Vlaanderen*, a Christian-inspired umbrella organization for over 500 healthcare organizations in Flanders, the Dutch-speaking part of Belgium. The core question of the ethical guideline is: How can we realize good care within a context of

cross-cultural diversity in our healthcare organizations in Flanders? First, we describe the method used in developing the guideline. Then, we present the two pillars of the guideline: (1) the ethical content (the core values in cross-cultural care) and (2) the organizational process (benchmarks for putting the values into practice). We end with a critical discussion of the guideline's strengths and limitations.

Development and content of the ethical guideline

Method

The Ethics Committee consisted of 31 members with senior experience in various disciplines in healthcare (physicians, nurses, pastoral workers, managers, ethicists, lawyers). The ethical guideline was developed according to a Delphi-inspired consensus meeting method (Jones & Hunter, 1995; Pope & Maysa, 1995) by which the committee members, with the help of external experts, attempted to achieve a consensus answer to the research question: "How can we realize ethically good care within a context of increasing cross-cultural diversity in Flemish healthcare organizations?" The full process consisted of carefully composed consecutive steps, combining theoretical reflection by means of literature review with ethical reflection and discussion: the moral intuitions and practices of the members of the committee were confronted with insights from the literature.

External expert consultations took place in the beginning, the middle and at the end of the process. These consultations guaranteed a thorough exchange of experiences and opinions, as well as an extensive review of the various drafts of the guideline. Consulted experts were people with daily experience in cross-cultural care (staff and management), people who represented the migrant and minority patients, health policy makers and non-healthcare experts who represent a general critical view. In sum, over 70 people took part in the discussion and reviewing process.

The entire process took place within an open and free atmosphere, thus allowing each participant to take part in the process without any form of pressure based on authority or function. In some cases, the consulted expert participated in the review process anonymously. The full process lasted about 4 years (from February 2007 until April 2011). The final draft of the guideline was approved by all the participants. Appendix A provides a detailed overview of the various stages of development.

Fundamental values in cross-cultural care: the ethical content

The theoretical foundations of the ethical guideline are to be found in the ethical perspective of care ethics (Gastmans, 2006; Tronto, 1993; Vanlaere & Gastmans, 2011a) and the Louvain tradition of personalist ethics (Janssens, 1980; Schotsmans, 1999; Selling, 1998; Vanlaere & Gastmans, 2011b). Against this background, the patient as person is the center of care, which happens within four concentric circles (see Fig. 1). The first and most inner circle contains the patient as a unique person and with it, all the caring activities that he finds important in his life (the personal and individual dimension of care). These caring activities shape our character and more or less show who we are (expressed by the things and activities we care about). The second circle is the relational circle. Here, we are directly related to people around us. In a care situation, we enter the circle of the clinical relationship with professional healthcare providers, our caregivers and our relatives. Applied to the ethical domain, this is the field of clinical ethics. The third circle is the circle of healthcare organizations. Applied to ethics, this contains organizational ethics, referring to the ethical responsibilities of the healthcare organization, determined by its

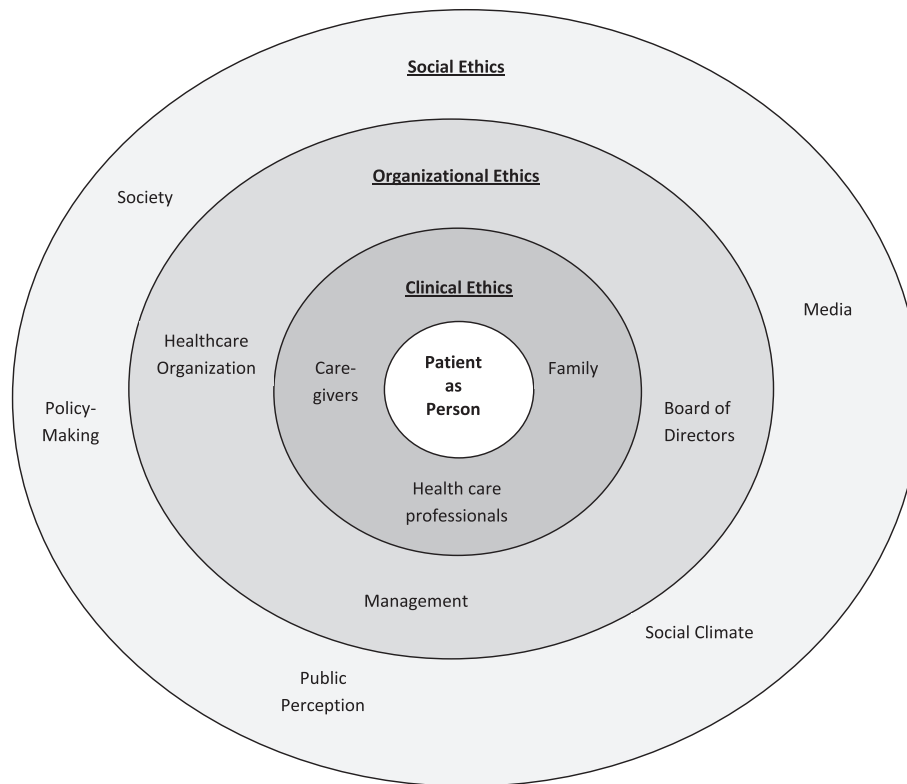


Fig. 1. Circles of personalist care ethics.

management and board of directors. The fourth circle contains the social dimension of care, the field of social ethics, determined by policy making, public perceptions, social climate, and the impact of media on society.

Against the background of these circles of personalist care ethics, we have determined seven fundamental values that are taken as general cornerstones of the ethical guideline concerning cross-cultural care (see also Fig. 2). All the values start from the patient as person, being the center of care.

Respect for the human person

The first and most fundamental value of the guideline is expressed in the personalist ideal of respect for the human person, adequately considered in a multidimensional way (viz. as an individual, relational and social being) (Janssens, 1980; Schotsmans, 1999; Selling, 1998; Vanlaere & Gastmans, 2011b). This means that respect for the human person implies explicit acknowledgment of the fact that every human being is unique (with highly individual physical and psychological characteristics, a personal history, a network of relations, a certain status in society, a personal philosophy of life and particular spiritual needs), fundamentally equal to other human beings (the value of equal dignity), substantially related to other persons (in relational contact with fellow human beings) and part of the larger social world (as a member of society) (Schotsmans, 1999). Furthermore, respect for the human person also implies acknowledgment of the human life as a *dynamic* process that is influenced by many factors and hence subject to development and change.

Consequently, cross-cultural care implies express avoidance of cultural stereotyping and the explicit acknowledgment that people are to be respected as unique beings and never to be reduced to being an object that may – or may not – come up to one's expectations. Patients are unique and fundamentally different from each other. At the same time they are equally worthy. A person's

dignity does not depend on certain characteristics (sex, race, nationality or cultural background) or capacities (mental or physical state).

A concrete example of this basic ethical attitude is present when the staff explicitly approaches the ethnically diverse patient as a person with many dimensions in the first place, and not as “a culture” with presumed standardized ways of treatment. Every person has a specific cultural background but this is only one of the person's dimensions. The same holds for the healthcare organization: clear and explicit acknowledgment that there is respect for patients' culture-based commitments and concerns is an important signal to everyone involved (patients, relatives, staff and management).

Commitment to dignity-enhancing care

Whether or not a certain action is ethically justified depends on the way in which it contributes to the realization of the most dignified solution for the human person (Janssens, 1980; Schotsmans, 1999). This means that the action has to be conducive to the human person as a whole, in all its various dimensions (physically, psychologically, relationally, historically, socially, and spiritually) (Gastmans, 2013).

According to this criterion, dignity-enhancing cross-cultural care implies that the vulnerable person receives optimal support on the physical, psychological, relational, historical, social and spiritual level. It is imperative that the patient can preserve his own identity in this regard as much as possible during the care relationship. He needs to feel respected as a person in the broad sense.

In this regard, it is important to acknowledge that dignity-enhancing care is not a fixed reality but a permanent assignment of everyone involved in the care relationship (Schotsmans, 1999). Though it may not always be achievable in practice to realize the

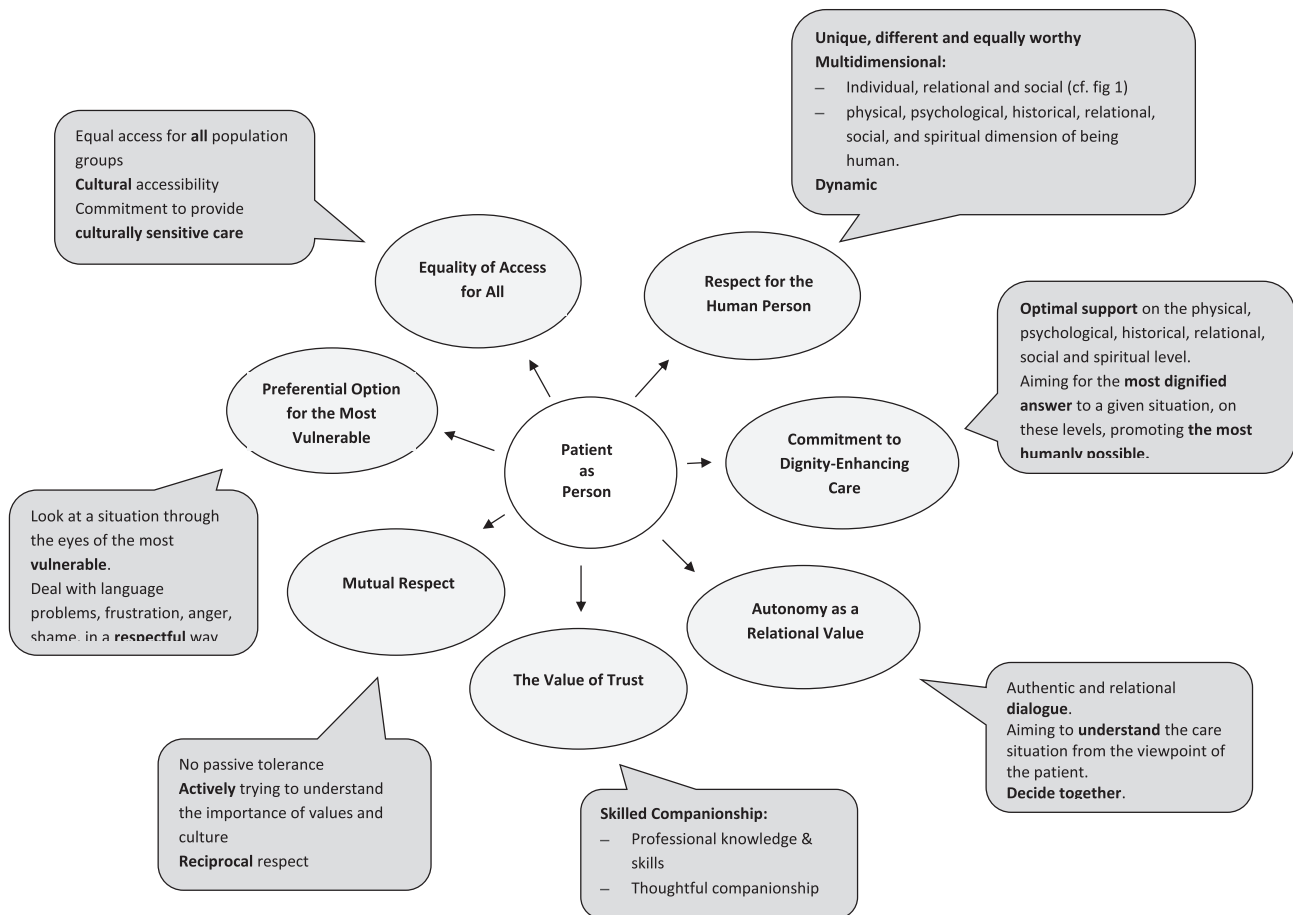


Fig. 2. Fundamental values in cross-cultural care.

full ideal of dignity-enhancing care, it remains imperative to aim for the best possible answer to a certain situation. Consequently, the ethical guideline appeals to the commitment of everyone involved to "promote the most humanly possible in light of the most humanly desirable" (Schotsmans, 1999, p. 18) within the context of cross-cultural diversity in healthcare.

A concrete example would be the way in which end-of-life care and mourning care are being organized. End-of-life and mourning practices are culturally highly diverse. They embody attitudes and rituals that are very important to people. It is imperative that staff and management take these cultural differences between people into account by respecting and supporting the cultural traditions in this regard (flexible visiting regulations in the last days, supporting the patient's last wishes, practices of laying out the body, of paying the last respects, of expressing grief, etc.), thus trying to realize the most dignified form of end-of-life and mourning care.

Autonomy as a relational value

In the Western culture, respect for autonomy is a very important value (Beauchamp & Childress, 2013). In the ethical guideline, we interpret autonomy not as mere individual self-determination but as a relational value (Janssens, 1980; Selling, 1998). This means that the patient expresses his wishes in a relational dialog with others and that everyone involved decides together, by means of an authentic dialog, what the most dignified answer to a certain situation can be.

Applied to the theme of cross-cultural care, respect for autonomy as a relational value implies two things. On the one hand, it

implies that the staff shows respect for the fact that the immigrant patients or residents interpret the care relationship and the care options within the framework of their own cultural identity. The staff's readiness to value patients and residents in their singularity as a person (broadly understood) is in itself a moral and professional attitude. On the other hand, it does not imply that health professionals have to give priority, without reservation, to every cultural value and belief of patients and residents because this might lead to harmful situations (Macklin, 1998).

Here, culturally-sensitive mealtime care serves as an example. Healthcare staff and management can meet patients' requests for halal or kosher food, for instance by making practical arrangements with a catering service or with the family. In case, however, the patient is restricted to specific dietary requirements that can only be guaranteed by the food from the hospital or nursing home, this request might not be (fully) realizable. Respect for autonomy as a relational value implies that the request is being taken seriously, that practical solutions are being sought in dialog, and that the reasons why the request eventually cannot be met, are being explained in a respectful and patient manner.

The value of trust

An important criterion for a good care relationship is trust (Dinc & Gastmans, 2011). Trust can only exist within the care relationship when the human person (in the broad sense) is being put central. In this regard, the healthcare staff needs to take two dimensions of the care relationship into account, viz. *knowledge and skills* on the one hand and *companionship* on the other hand (Titchen, 2000;

Vanlaere & Gastmans, 2011a). Both are important in realizing good care in the context of cross-cultural diversity.

The first dimension is that of professional expertise in providing care (knowledge and skills). This means that the chosen actions and treatments in care are based on professional skills and that they improve the patient's quality of life in the most skillful way. The second dimension is that of thoughtfulness in providing care (companionship). It refers to the way in which care is being given: with a respectful attitude, expressing hospitality during the first moment of contact, offering friendly treatment, showing patience while double-checking whether all the information is clear for the patient, providing support during hard times, etc. Here also, trust is not a fixed fact but something that has to be built up during and throughout the care relationship.

Culturally-based gender issues in diagnostic and therapeutic care may serve as an example here. In some cultures, modesty plays an important role in social contact. This might lead to culturally-based strong feelings of shame or timidity when it comes to bodily contact or nudity. In healthcare settings, diagnostic research and therapeutic treatment can lead to difficulties or even conflicts, for instance when the patient does not want to be examined by a healthcare provider from the opposite sex. In this regard, it is important to check and see whether a healthcare provider from the same sex is available to do the examination. When this is not possible, it is appropriate to take these sensitivities respectfully into account by explaining why it is not possible, by expressing the acknowledgment that this is not evident for the patient, by providing clear information about the various steps in the examination, by proposing gradual examination (if possible), by easing the patient through showing patience during the examination.

Mutual respect

Trust can only exist in a care relationship that is characterized by *mutual respect* (Dinç & Gastmans, 2011). This means at first that health professionals empathically support patients, residents and family members in giving room to their cultural-based opinions, wishes, and actions within the care relationship. This means that respect is not to be understood as passive tolerance. Rather, it is an attitude of actively trying to understand which cultural elements are important to the patient and actually searching for ways to incorporate these elements into the given care (like in trying to arrange adjusted end-of-life or mourning care, or mealtime care).

Mutual respect also implies that the non-Western patient shows respect for the ethical foundations of the Western healthcare systems and for the staff who provide care within the framework of these values. Essential values in this regard are: equality of treatment, prohibition of discrimination, gender equality, prohibition of violence and oppression, of abuse and of violation of bodily integrity, freedom of opinion, etc. (Leininger, 1993; Macklin, 1998). In this regard, it always has to be made clear to the patient and relatives that everything will be done to ensure culturally sensitive care, but that it is not always possible (like for instance when a healthcare provider from the same sex is not available).

Preferential option for the most vulnerable

The moral quality of a society can be assessed by the way in which it treats all its members, and most specifically, the least advantaged and most vulnerable members (Denier, 2007; Rawls, 1971). Consequently, their position is the touchstone of a just society and the policies within it: do our choices and actions actually improve the situation of those members?

Healthcare organizations that aim to provide good care within a context of cross-cultural diversity have to take into account that migrant and minority patients are often very vulnerable for various reasons (difficult migration process, problems with language, bad

socioeconomic position, discrimination on housing and labor market, experiences of racism, etc.). Looking at a situation through the eyes of the most vulnerable within the context of cross-cultural care implies then, that the caregiver respectfully takes into account that the migrant patient or resident may have difficulties with the language, may experience frustration or even anger because he feels powerless in many ways, or experiences shame because of poor socioeconomic status. Providing care with a preferential option for the most vulnerable implies that one takes these aspects of cross-cultural diversity into account in a respectful way. Taking active measures to overcome language barriers (interpreter services, cultural brokerage) serves as an example here.

Equality of access for all

The final value is founded on the ethical principle of equal access for all. Just healthcare organizations have to be equally accessible for all, without discrimination in race, sex, rank or status (Denier, 2007).

Equality of access for all population groups to decent-quality healthcare implies not only financial and geographic accessibility, but also cultural accessibility. This implies that healthcare organizations and care practices are culturally sensitive and always approachable for cultural-based needs of all the patients.

The most appropriate example here is a clear and transparent policy regarding cross-cultural care, developed by the healthcare organization as a whole. Such a policy would include for instance informational brochures in various languages, training of contact persons for cross-cultural issues and questions, development of clear and specific guidelines for the staff on dealing with concrete matters in cross-cultural care, like language barriers, gender issues, mealtime care, end-of life care, treatment compliance, etc.

Implications for healthcare practice: the organizational process

Ethics is not only about putting nice values on paper. It is also about realizing them in daily practice. What exactly do these fundamental values imply on the level of clinical care and healthcare management within concrete healthcare organizations?

Essentially, the fundamental values create the ethical soil on which an atmosphere of culturally sensitive care can be built. They shape the ethical climate within which an *active and dynamic process* based on the common engagement to take up the cross-cultural view throughout intercultural communication and action can happen on four different levels: (1) the organization, (2) staff, (3) care receivers, and (4) care supply. The ethical guideline provides exemplary recommendations on these four levels. These recommendations do not directly and causally follow from the respective fundamental values, as in a causal one-on-one relationship. Rather, they are to be understood as emanating from the ethical atmosphere created by the fundamental values together.

Healthcare organizations

For healthcare organizations, the choice for a cross-cultural policy is a continuous and active process, specifically tailored to the needs and characteristics of the particular organization and its population. On this level, acknowledging the importance of having broad *knowledge* of the various cross-cultural dimensions of the organization, together with a dynamic and long-term *strategy*, are necessary. Developing a cross-cultural policy also implies various *activities* and strong *cooperation* with external partners. Table 1 contains specifics of these recommendations for healthcare organizations.

Staff

Realizing good cross-cultural care depends, to an important extent, on good cooperation between management and staff, as

Table 1
Recommendations for healthcare organizations.

Knowledge	To have knowledge of the specific characteristics of one's country as a multicultural society; to have knowledge of its own geographical location within this field, and of the cultural diversity of the patient population in the near surroundings: Who are our audience? Are we actually accessible for all? Which actions can we take to improve?
Long-term strategy	To develop a clear policy with regard to strategic long-term goals; to describe the fundamental values that are the cornerstones of the organization, and to describe their implications for cross-cultural care within the organization.
Activities	To realize and support activities (lectures, seminars and discussion meetings) within the organization that are explicitly related to cross-cultural diversity (Where do we stand? What are our needs? What can we do? How do we deal with it?). It is also important to have an internal contact person or information desk where everyone can get to for information on cross-cultural care. Listing the difficulties with regard to cross-cultural care is a good way of assessing the intercultural climate within the organization.
Cooperation	To work together with external partners like public services for minorities, ethnic communities, services for diversity and integration, schools and universities, training centers, translation and interpreting centers, etc.

well as between managerial staff and bedside staff. Particular recommendations contain attention to the *common engagement* of everyone to realize good cross-cultural care, *training facilities*, practical needs for providing cross-cultural care, possibilities for *feedback* on cross-cultural issues, and to the aspect of *cultural diversity* of staff and management (see Table 2).

Care receivers

Good care in the context of cross-cultural diversity starts from the particular needs of every patient. Taking the personalist approach to care ethics into account, particular recommendations imply treatment of every patient as a *unique person*, commitment to enter into *cross-cultural dialog*, attention to the element of *mutual respect*, and consideration of the needs and concerns of *autochthonous patients* within the healthcare organization (see Table 3).

Care supply

On the level of care supply, it is important to pay attention to cultural-based determinants of trust in the care relationship. This implies that critical questions are being asked regarding the existence of *barriers* in the cross-cultural care relationship within the organization, the way in which *language matters* are being dealt with, the presence of adequate *clinical guidelines* regarding particular cross-cultural issues, structural attention to recurring difficulties, and the creation of a broader *cross-cultural atmosphere* within the organization (see Table 4).

Discussion & conclusion

Strengths

Organizational ethics perspective

This guideline is the first *organizational ethics* guideline on cross-cultural diversity for healthcare organizations both in Flanders and worldwide. As such, it meets an important need,

expressed by existing studies and reports on addressing existing ethnic disparities in health and care. From existing research (Gushulak et al., 2011; Kirmayer et al., 2011; Priebe et al., 2011; WHO Europe MFH Project Group, 2004), we learn that the degree of sensitivity to deal with cross-cultural issues strongly depends from the organizational context, action and programs in this regard (investment in person-oriented services, increasing organizational flexibility, increasing the knowledge of migrant population experiences and existing health disparities and inequities, cultivate the interpretation of culture as one of the many dimensions of being human, training facilities for staff, provision of information, working with community organizations, providing resources for dealing with language barriers, etc.). Organizational self-assessment is an essential feature of culturally competent healthcare (Chun, 2009; Dotson & Nuru-Jeter, 2012). The surplus value of the ethical perspective is that it supplies the need for *ethical guidance* (Turner, 2003) in cross-cultural care by describing (1) a general framework of fundamental values and ethical attitudes that are relevant in the context of cross-cultural care (i.e. the ethical content), and (2) a concrete framework for reflection and action on four levels within the healthcare organization (i.e. the organizational process).

Between moral imperialism and ethical relativism

The ethical guideline discusses the relevance of fundamental values for the field of cross-cultural care without remaining on the abstract level. Rather, it aims to integrate abstract ethical reasoning with concrete recommendations for dealing with cross-cultural issues in clinical care and healthcare management. As such, the guideline offers an applied ethics perspective, which aims for ethically based pragmatic and constructive solutions to cross-cultural issues in care.

The guideline thereby adopts a *middle course* between moral imperialism and ethical relativism. As such, it meets an important critique on current mainstream bioethics which states that it fails to attend to the multiple moral worlds of patients and families (Macklin, 1998; Ten Have & Gordijn, 2011; Turner, 2003).

Table 2
Recommendations regarding staff.

Common engagement	There is explicit engagement from all the staff to contribute to the realization of good cross-cultural care. There is a common willingness to critical self-evaluation and improvement when necessary (Do we deserve the trust of our non-Western patients? Can we improve? How can we do this? Where can we do this?)
Training facilities	There are sufficient training facilities for the staff in order to improve their cross-cultural competencies.
Practical needs	There is sufficient attention for the practical needs of the staff concerning cross-cultural care (interpreter services, cultural brokerage, contact information of an imam or rabbi, an organizational ethics policy concerning cross-cultural issues in care, specific knowledge concerning specific cultural or religious aspects of care, etc.)
Feedback	There are sufficient possibilities for feedback on cross-cultural issues in care (by means of interpersonal ad hoc meetings, or by frequent organization of activities).
Staff diversity	There is sufficient cultural diversity in healthcare personnel and management staff, on all the levels and departments in the healthcare organization.

Table 3
Recommendations regarding care receivers.

<i>Unique person</i>	Every patient and resident is being treated as a whole person, whereby the various dimensions (physical, psychological, historical, relational, social and spiritual) are being incorporated in the care process. Every patient is being treated as a unique person with a particular life story and specific cultural background.
<i>Cross-cultural dialog</i>	There is sufficient attention for the intercultural differences between the needs of various patients, as well as for interpersonal differences within one culture. One tries to detect what is important for every unique patient by means of a respectful cross-cultural dialog.
<i>Mutual respect</i>	Mutual respect is the basis of the cross-cultural care relationship. This means that the personality and identity of the healthcare staff are also to be respected by the care receivers, and that the ethical framework from which they provide care are also part of the care relationship.
<i>In relation with autochthonous patients</i>	The needs and concerns of autochthonous patients regarding cross-cultural issues do not disappear from sight (for instance when patients from different cultures share a hospital room, when patients show racist behavior towards immigrant staff).

Especially since the guideline's fundamental values are to be understood as open *ethical cornerstones* in the *process* of a joint cross-cultural *dialog* within the organization, they do not aim to *impose* one morality for all by giving fixed answers to particular situations in daily healthcare practices. Neither does the guideline take up a 'laissez-faire' or 'anything goes' philosophy, whereby everything has to be accepted or endorsed in the name of cross-cultural peace. Certain values, like prohibition of discrimination, gender equality, prohibition of violence and oppression, of abuse and of violation of bodily integrity, freedom of opinion, etc. (Leininger, 1993; Macklin, 1998) are explicitly stressed as the ethical foundations of a just and fair society. Based upon these ethical foundations, the process of cross-cultural dialog and moral deliberation has to take place.

An active and dynamic organizational process

The guideline provides an ethical framework within which various cross-cultural issues in particular healthcare organizations can be dealt with. As such, the guideline challenges healthcare professionals and management to actively focus at the theme by offering the ethical tools to develop their own ethics policy concerning cross-cultural care. Consistent with the organizational recommendations from the international literature (Chun, 2009; Dotson & Nuru-Jeter, 2012) the guideline shapes the organizational preconditions for culturally competent care to take place in the clinical context.

Limitations

Possible bias

The ethical guideline is developed by the ethics committee of a large, Christian-inspired umbrella organization for healthcare institutions in Flanders. As such, the fundamental values in it are based upon a Christian inspired personalist ethics. This raises questions with regard to bias. Is the guideline only applicable for its member-institutions? Can it have a broader impact, going beyond its member institutions, and even beyond Flanders? There are three reasons to believe it can: (1) the method of development was based upon extensive consultation rounds with *external* experts, thereby avoiding tunnel vision in the development of the ethical framework. (2) The ethical guideline is phrased in a language that is non-exclusive and open to everyone. As such, the line of reasoning aims to be acceptable also to non or other-religious people and institutions. Furthermore, the guideline is publicly accessible for everyone. (3) The personalist ideal of respect for the human person considered in a multidimensional way corresponds with the recommendations from the international literature, which propose to shift away from a cultural expertise approach and provide greater focus on each patient as an individual (Dotson & Nuru-Jeter, 2012; Kai et al., 2007). In these studies, a holistic approach is taken by seeing patients as whole people, taking into account their physical, psychological, social and spiritual needs (Owen & Khalil, 2007).

Table 4
Recommendations regarding care supply.

<i>Barriers</i>	Are supply and demand sufficiently attuned when it comes to cross-cultural care? Which barriers can be identified? How can they be identified? Is there sufficient cooperation with external partners in this regard? Are there tracks yet unexplored?
<i>Language</i>	Is the language barrier a serious problem in the healthcare organization? How can it be overcome? Which efforts have already been done? Is there sufficient knowledge and use of existing possibilities (like cultural brokerage, professional interpreters, use of pictograms) or is there still room for improvement?
<i>Clinical guidelines</i>	Is there sufficient attention to cultural determinants of disease perception (expression of symptoms), of medical examination (gender issues), of treatment conditions (porcine or alcoholic products, treatment during Ramadan, cultural views on blood transfusion, transplantation, abortion), of caring behavior (like visiting hours and mealtime care), of end-of-life care (palliative care, euthanasia), of mourning care (practices of laying out the body, rituals), etc? Is everything more or less clear in this regard, or do we need to develop guidelines in order to improve our care within the organization?
<i>Management of recurring difficulties</i>	Is there sufficient attention for recurring difficulties in cross-cultural care, which lead to less qualitative care for migrant and minority patients? Are there structural efforts in working towards solutions (like trainings in cross-cultural conflict management, development of ethical guidelines in dealing with culturally sensitive issues, clear formulation of limits in care, etc.).
<i>Cross-cultural atmosphere</i>	Is a sufficiently broad perspective being taken on cross-cultural diversity in care? Cross-cultural care is not restricted to the patient–physician relationship. Creating a cross-cultural atmosphere within the healthcare organization also involves aspects like cross-cultural diversity in healthcare personnel, attention to special religious feasts, having an open and friendly reception desk, etc. A warm cross-cultural atmosphere within the organization creates possibilities to adjust the care supply to existing needs.

Translation to particular healthcare context is necessary

Development of an organizational ethics policy concerning cross-cultural care is a very particular process, tailor-made for each organization and each particular situation. The primary aim of the ethical guideline is to provide the cornerstones of an ethically inspired cross-cultural climate within healthcare institutions, thereby motivating healthcare staff and management to actively carry out a reflective and dialogical process on the various cross-cultural issues that they meet in care. As such, the guideline does not provide concrete answers to particular questions that arise from daily care practices. Because every healthcare institution has its own specific characteristics when it comes to geographical location, socio-cultural context, the specific composition of its ethnically diverse population (High or low diversity? Which cultures? Which languages?), etc., the ethical guideline requires specific translation to the reality of individual healthcare situations. In accordance with the literature on the applicability of ethical models in cross-cultural care (Durante, 2009; Turner, 2004) we state that there is no ethical “magic key” or “Golden Rule” to answer concrete questions like “What exactly is a sufficient amount of ethnically diverse healthcare personnel?”, “Which training facilities should be offered?”, or “When is our attention to the intercultural differences between people sufficient?” The concrete answers will have to be found by the particular health professionals through the dialogical process carried out in the individual institutions.

In this regard it is essential for healthcare staff and management to acknowledge and actively go along in the continuous dynamics of the process. This requires time, attention, collaboration, dialog, creativity and pioneering, exchange of information and good practices, within a process of trial and error. An important weakness of the ethical guideline is that its success ultimately depends on this particular and constant engagement of everyone involved to actively keep on searching for the most dignified solution for everyone, regardless of their cultural background.

Limits of cross-cultural care

A very important issue that has not been touched by the ethical guideline concerns the scope and limits of cross-cultural care. Questions such as “What should be done when there is no mutual respect from the side of the patient?”, “What should be done when we reach the limits of cross-cultural dialog and a consensus cannot be found?” In short, what should be done when the ethical values cannot offer help in finding a solution? Should people stop, then, providing culturally sensitive care? Should patients be forced to abide by the terms of the hospital? These issues, which are at the core of the present discussion in Western countries dealing with an increasingly diverse population, require further research based on an inquiry of best practices of dealing with situations of cross-cultural conflict.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.socscimed.2013.03.045>.

References

- Árnason, V. (2001). Universal principles in particular contexts. *Medicine, Health Care and Philosophy*, 4, 237–240.
- Asanin, J., & Wilson, K. (2008). “I spent nine years looking for a doctor”: exploring access to healthcare among immigrants in Mississauga, Ontario, Canada. *Social Science & Medicine*, 66, 1271–1283.
- Baker, R. (1998). A theory of international bioethics: multiculturalism, post-modernism, and the bankruptcy of fundamentalism. *Kennedy Institute of Ethics Journal*, 8(3), 201–231.
- Beauchamp, T., & Childress, J. (2013). *Principles of biomedical ethics*. New York: Oxford University Press.
- Betancourt, J. R., Green, A. R., & Carillo, J. E. (2000). The challenges of cross-cultural healthcare – diversity, ethics and the medical encounter. *Bioethics Forum*, 16(3), 27–32.
- Betancourt, J. R., Green, J. E., Carillo, J. E., & Park, E. R. (2005). Cultural competence and healthcare disparities: key perspectives and trends. *Health Affairs*, 24(2), 49–505.
- Bischoff, A. (2003). *Caring for migrant and minority patients in European hospitals. A review of effective interventions*. Vienna: Ludwig Boltzmann Institute.
- Bollini, P., & Siem, H. (1995). No real progress towards equity: health of migrants and ethnic minorities on the eve of the year 2000. *Social Science & Medicine*, 41(6), 819–828.
- Brannigan, M. (2000). Cultural diversity and the case against ethical relativism. *Health Care Analysis*, 8, 321–327.
- Carrasco-Garrido, P., Jiménez-García, R., Hernández Barrera, V., López de Andrés, A., & Gil de Miguel, Á. (2009). Significant differences in the use of healthcare resources of native-born and foreign born in Spain. *BMC Public Health*, 9, 201.
- Carta, M., Bernal, M., Hardoy, M., & Haro-Abad, J. M. (2005). Migration and mental health in Europe. *Clinical Practice and Epidemiology in Mental Health*, 1(1), 1–13.
- Chun, M. B. J. (Sept–Oct 2009). Cultural compliance issues in healthcare. *Journal of Health Care Compliance*, 27–32.
- Coward, H. G., & Ranatakul, P. (1999). A cross-cultural dialogue on healthcare ethics. *Studies in Religion*, 29(2), 217–218.
- Cristancho, S., Garces, D. M., Peters, K. E., & Mueller, B. C. (2008). Listening to rural Hispanic immigrants in the midwest: a community-based participatory assessment of major barriers to healthcare access and use. *Qualitative Health Research*, 18, 633–646.
- Denier, Y. (2007). *Efficiency, justice and care. Philosophical reflections on scarcity in health care*. Dordrecht: Springer.
- Dinç, L., & Gastmans, C. (2011). Trust and trustworthiness in nursing: an argument-based literature review. *Nursing Inquiry*, 19, 223–237.
- Donnelly, P. L. (2000). Ethics and cross-cultural nursing. *Journal of Transcultural Nursing*, 11(2), 119–126.
- Dotson, E., & Nuru-Jeter, A. (2012). Setting the stage for a business case for leadership diversity in healthcare: history, research and leverage. *Journal of Healthcare Management*, 57(1), 35–44.
- Dunlop, S., Coyte, P. C., & McIsaac, W. (2000). Socio-economic status and the utilization of physician's services: results from the Canadian National Population Health Survey. *Social Science & Medicine*, 51(1), 123–133.
- Durante, C. (2009). Bioethics in a pluralistic society: bioethical methodology in lieu of moral diversity. *Medicine, Health Care and Philosophy*, 12, 35–47.
- Fiscella, K., Franks, P., Gold, M. R., & Clancy, C. M. (2000). Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. *Journal of the American Medical Association*, 283, 2579–2584.
- Gastmans, C. (2006). The care perspective in healthcare ethics. In A. Davis, V. Tschudin, & L. De Raeye (Eds.), *Essentials of teaching and learning in nursing ethics. Perspectives and methods* (pp. 135–148). Edinburgh: Elsevier.
- Gastmans, C. (2013). Dignity enhancing care for persons with dementia and its application to advance euthanasia directives. In Y. Denier, C. Gastmans, & A. Vandeveld (Eds.), *Justice, luck and responsibility in health care. Philosophical background and ethical implications for end-of-life care*, 2012 (pp. 145–165). Dordrecht: Springer.
- Gushulak, B. D., Pottie, K., Roberts, J. H., Torres, S., & DesMeules, M. (2011). Migration and health in Canada: health in the global village. *Canadian Medical Association Journal*, 183(12), E952–E958.
- Hargreaves, S., Friedland, J. S., Gothard, P., Saxena, S., Millington, H., Eliahoo, J., et al. (2006). Impact on and use of health services by international migrants: questionnaire survey of inner city London A&E attenders. *BMS Health Services Research*, 6, 153.
- Hawryluck, L., Bouali, R., & Danjoux Meth, N. (2011). Multi-professional recommendations for access and utilization of critical care services: towards consistency in practice and ethical decision-making processes. *Journal of Law, Medicine and Ethics*, (2), 254–262.
- Henley, A., & Schott, J. (1999). *Culture, religion and patient care in a multi-ethnic society – A handbook for professionals*. London: Age Concern Books.
- Hernández-Quevedo, C., & Jiménez-Rubio, D. (2009). A comparison of the health status and healthcare utilization patterns between foreigners and the national population in Spain: new evidence from the Spanish National Health Survey. *Social Science & Medicine*, 69, 370–378.
- Ho, A. (2006). Family and informed consent in multicultural setting. *The American Journal of Bioethics*, 6(1), 26–28.
- Hultsjö, S., & Hjelm, K. (2005). Immigrants in emergency care: Swedish healthcare staff's experiences. *International Nursing Review*, 52, 276–285.

- Ivanov, L., & Buck, K. (2002). Healthcare utilization patterns of Russian-speaking immigrant women across age groups. *Journal of Immigrant Health*, 4, 17–27.
- Janssens, L. (1980). Artificial insemination: ethical considerations. *Louvain Studies*, 8, 3–29.
- Jecker, N. S. (2010). Sources of normativity: how multicultural values emerge. *The American Journal of Bioethics*, 3(2), 16–18.
- Jones, J., & Hunter, D. (1995). Qualitative research: consensus methods for medical and health services research. *British Medical Journal*, 311, 376.
- Kagawa-Singer, M., & Blackhall, L. J. (2001). Negotiating cross-cultural issues at the end of life: "You got to go where he lives." *The Journal of the American Medical Association*, 286(23), 2993–3011.
- Kai, J., Beavan, J., Faul, C., Dodson, L., Gill, P., & Beighton, A. (2007). Professional uncertainty and disempowerment responding to ethnic diversity in healthcare: a qualitative study. *PLoS Medicine*, 4(11), 1766–1774.
- Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., et al. (2011). Common mental health problems in immigrants and refugees: general approach in primary care. *Canadian Medical Association Journal*, 183(12), E959–E967.
- Koch, T., Braun, K., & Pietsch, J. (2000). Multicultural perspectives in bioethics: end-of-life decisionmaking. *Cambridge Quarterly of Healthcare Ethics*, 9, 123–127.
- Leininger, M. (1993). *Cultural diversity and universality theory*. Newbury Park: Sage.
- Lindert, J., Schouler-Ocak, M., Heinz, A., & Priebe, S. (2008). Mental health, healthcare utilization of migrants in Europe. *European Psychiatry*, 23, 14–20.
- Macklin, R. (1998). Ethical relativism in a multicultural society. *Kennedy Institute of Ethics Journal*, 8(1), 1–22.
- Mladovsky, P. (2007). Migrant health in the EU. *Eurohealth*, 13, 9–11.
- Moody, H. (1998). Cross-cultural geriatric ethics: negotiating our differences. *Generations*, 22(3), 32–40.
- Norredam, M., Mygind, A., Nielsen, A. S., Bagger, J., & Krasnik, A. (2007). Motivation and emergency room visits among immigrants and patients of Danish origin. *European Journal of Public Health*, 17, 497–502.
- Norredam, M., Nielsen, S. S., & Krasnik, A. (2010). Migrant's utilization of somatic healthcare services in Europe – a systematic review. *European Journal of Public Health*, 20, 555–563.
- Owen, S., & Khalil, E. (2007). Addressing diversity in mental healthcare: a review of guidance documents. *International Journal of Nursing Studies*, 44(2007), 467–478.
- Pope, C., & Mays, N. (1995). Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *British Medical Journal*, 311, 42–45.
- Priebe, S., Sandhu, S., Dias, S., Gadini, A., Greacen, T., Ioannidis, E., et al. (2011). Good practices in healthcare for migrants: view and experiences of care professionals in 16 European countries. *BMC Public Health*, 11, 187.
- Rawls, J. (1971). *A theory of justice*. Cambridge: Harvard University Press.
- Schotsmans, P. (1999). Personalism in medical ethics. *Ethical Perspectives*, 6(1), 10–20.
- Schulze, B., Trummer, U., Krajic, K., & Pelikan, J. M. (2003). *Needs assessment kit for assessing the needs of migrant patients and staff*. Vienna: Ludwig Boltzmann Institute.
- Selling, J. (1998). The human person. In B. Hoose (Ed.), *Christian ethics: An introduction* (pp. 95–109). London: Cassell.
- Ten Have, H., & Gordijn, B. (2011). Diversity and bioethics. *Medicine, Health Care and Philosophy*, 14, 227–228.
- Titchen, A. (2000). *Professional craft knowledge in patient-centered nursing and facilitation of its development* (Doctoral dissertation). UK: University of Oxford.
- Trevino, F. M. (1999). Quality of health care for ethnic/racial minority populations. *Ethnicity & Health*, 4, 153–164.
- Tronto, J. (1993). *Moral boundaries: A political argument for an ethic of care*. New York: Routledge.
- Tugwell, P., Ottie, K., Welch, V., Ueffing, E., Chambers, A., & Feightner, J. (2011). Evaluation of evidence-based literature and formulation of recommendations for the clinical preventive guidelines for immigrants and refugees in Canada. *Canadian Medical Association Journal*, 183(12), E933–E938.
- Turner, L. (2002). Bioethics and end-of-life-care in multi-ethnic settings: cultural diversity in Canada and the USA. *Mortality*, 7(3), 285–301.
- Turner, L. (2003). Bioethics in a multicultural world: medicine and morality in pluralistic settings. *Health Care Analysis*, 11(2), 99–117.
- Turner, L. (2004). Bioethics in pluralistic societies. *Medicine, Health Care and Philosophy*, 7, 201–208.
- Vanlaere, L., & Gastmans, C. (2011a). To be is to care: a philosophical-ethical analysis of care with a view from nursing. In C. Leget, C. Gastmans, & M. Verkerk (Eds.), *Care, compassion and recognition: an ethical discussion* (pp. 15–31). Peeters: Leuven.
- Vanlaere, L., & Gastmans, C. (2011b). A personalist approach to care ethics. *Nursing Ethics*, 18(2), 161–173.
- Westra, A. E., Willems, D. L., & Smit, B. J. (2009). Communicating with Muslim parents: "the four principles" are not as culturally neutral as suggested. *European Journal of Pediatrics*, 168, 1383–1387.
- WHO Europe MFH Project Group. (2004). *The Amsterdam declaration. Towards migrant-friendly hospitals in an ethno-culturally diverse Europe*. www.mfh-eu.net Accessed 30.01.12.